

THE TIMING OF THIS REPLY AFTER DR. JASON NOT +
INDEED TO CLINICAL BRIEF HISTORY OF MEDICATION + FOG PUT
AS PATHOLOGICALLY PSYCHOTIC OR PSYCHOTICALLY FALSELY



IS HIGHLY
SUSPICIOUS



CGS

A CEEERIAN GROUP COMPANY

September 26, 2025

Medicare Number of Beneficiary:

*3MR95

JOHN FOUTS
184 CEDARVIEW DR
SHEPHERDSVILLE, KY 40165-6105

I FIND IT INCREDIBLY INTERESTING THAT
THIS CN FOG PUT WAS SENT SEPTEMBER 26th
FOR AN APPEAL FOG PUT. IT SEEMS ALMOST AS IF
WE MAY BE GOING BACKWARDS TO TRY TO
FALSIFY REASONS FOR CHANGING TESTS.
HOW CAN I REQUEST ALL CMS RECORDS FOR

Beneficiary Contact Information

1-800-MEDICARE
or
1-800-633-4227

Provider Contact Information

If you have questions, write or call: WHEN FOOT
CGS Administrators, LLC - J15 IS UNAPPROVED
P.O. Box 20006 BLOCKED +
Nashville, TN 37202 ICR + IS ALSO OWNED
(866) 590-6703

MEDICARE APPEAL DECISION

Re: Appeal # 1-15517729254
Medicare Beneficiary: John Fouts

I AM SURE I AM NOT THE
ONLY ONE THAT FEELS THIS
TO BE VERY STRONG

Dear John Fouts,

This is a copy of the Medicare decision letter sent to University of Kentucky who requested this appeal. You are not required to take any action. Please keep this copy for your records.

This letter is to inform you of the decision on your Medicare appeal. An appeal is a new and independent review of a claim. You are receiving this letter because you requested an appeal for the outpatient services provided by University of Kentucky. CGS Administrators, LLC - J15 was contracted by Medicare to review your appeal.

The appeal decision is unfavorable.

Claims Contained in this Decision Letter

#	Beneficiary	Claim #	Dates of Service	Claim Decision
1	Fouts, J.	22519900592507KYA	04/01/2025 – 04/01/2025	Unfavorable

Appeal # 1-15517729254

More information on the decision is provided below. If you disagree with the decision, you may appeal to a Qualified Independent Contractor (QIC). Your appeal of this decision must be made in writing and received by the QIC within 180 days of receipt of this letter. You are presumed to have received this decision five days from the date of the letter unless there is evidence to show otherwise. However, if you do not wish to appeal this decision, you are not required to take any action. For more information on how to appeal this decision, see the section at the end of this letter titled, "Important Information about Your Appeal Rights."

A copy of this letter was also sent to John Fouts.

Summary of the Facts – Claim # 1 of 1

Beneficiary	Claim #	Dates of Service	Claim Decision
Fouts, J.	22519900592507KYA	04/01/2025 – 04/01/2025	Unfavorable

- A claim was submitted for fluorodeoxyglucose F-18 FDG, diagnostic, per study dose, up to 45 millicuries (A9552 X 1 unit) and brain imaging, positron emission tomography (PET); metabolic evaluation (78608-PI X 1 unit).
- An initial determination on this claim was made on August 01, 2025.
- The outpatient services were denied because an automatic diagnosis to procedure code edit determined the information received did not support the services were reasonable and necessary as outlined in the National Coverage Determination (NCD).
- On August 15, 2025, we received a request for a redetermination.
- The request included: Food and Drug Administration (FDA) label for fludeoxyglucose F-18, a copy of the NCD for FDG PET for Dementia and Neurodegenerative Diseases (220.6.13), Uniform Billing Claim Form (UB-04) of 131 bill type, progress notes, physician orders, imaging reports, laboratory results, medication administration record, and a referral letter.

Decision

We have determined that the above claim is not covered by Medicare. We have also determined that University of Kentucky is responsible for the cost of these services.

Explanation of the Decision

The services originally denied because a covered diagnosis was not billed on the claim. The services are payable by Medicare when the coverage guidelines are met as outlined by the National Coverage Determination (NCD) for FDG PET for Dementia and Neurodegenerative Diseases (220.6.13). However, the documentation submitted did not support the guidelines as outlined within the NCD.

The NCD allows coverage for positron emission tomography (PET) computed tomography (CT) scans using either fluorodeoxyglucose F-18 or fludeoxyglucose F-18 for patients with recent dementia diagnoses and cognitive decline for at least six months meeting criteria for both

Appeal # 1-15517729254

Alzheimer's disease (AD) and frontotemporal dementia (FTD). The patient must have undergone a comprehensive clinical evaluation, including medical history, physical and mental status exams, cognitive testing, laboratory tests, and imaging like magnetic resonance imaging (MRI) or CT, conducted by a physician experienced in dementia diagnosis. The PET CT scan helps clarify the diagnosis and help guide further treatment only when other evaluations are inconclusive. The documentation included physician progress notes, a physician order, an imaging report, and a medication administration record. However, the submission did not include relevant laboratory test results such as vitamin B-12 and thyroid hormone to support that other causes for clinical symptoms were ruled out before the services were rendered. In addition, the submission did not include the results of mental status exams and cognitive tests to support a recent diagnosis of dementia and other diagnostic tests were inconclusive. Finally, the documentation does not support that the services were ordered and rendered as billed. Although fluorodeoxyglucose F-18 was billed on the claim, the documentation supports that fludeoxyglucose F-18 was ordered and rendered. The submission did not include an adjusted Uniform Billing Claim Form (UB-04) of 137 bill type with the correct Healthcare Common Procedure Coding System (HCPCS) code for the radiotracer that was rendered. The coverage conditions were not met as outlined in the NCD. Therefore, the services remain denied.

Who is Responsible for the Bill?

After determining that the services will not be covered by Medicare, we must determine who is financially liable for the denied services. When services are denied under §1862(a)(1), §1862(a)(9), or §1879(g) of the Social Security Act (the Act), we must determine if the beneficiary and the provider either knew or could reasonably be expected to know that the services would not be covered. This is known as the limitation on liability provision of §1879 of the Act.

If the beneficiary was informed by their provider in writing in advance of receiving the services that Medicare may not make payment (through receipt of an Advance Beneficiary Notice of Noncoverage (ABN)), the beneficiary may be responsible for the cost of the denied services. If the provider knew or could reasonably be expected to know the services would not be covered, but the beneficiary did not have such knowledge, then the provider may be responsible for the cost of the denied services.

There is no evidence to indicate that the provider notified the beneficiary in advance that the services would not be covered by Medicare. Therefore, we have determined that the beneficiary did not know and could not reasonably have been expected to know that the services would not be covered.

In addition, we have determined that the provider either knew or could reasonably be expected to know that the services would not be covered. This decision was made based on the coverage limitations provided in the "Explanation of the Decision" section in this letter.

Since the provider has been determined to have had knowledge of the non-covered services, the provider is liable for the cost. The provider may not bill the beneficiary for the cost of the denied services and must refund any monies collected from the beneficiary including any copayment, coinsurance, or deductible.

Additional Information for the Beneficiary

The beneficiary is not responsible for any non-covered charges resulting from this decision, except for any charges for services never covered by Medicare. If the beneficiary has paid for the services, they may be entitled to a refund. To get this refund, the beneficiary should file a written request for payment within six months of the date of this letter and send the following items:

- A copy of this notice,
- The bill received for the services, and
- The payment receipt, cancelled check, and any other evidence showing that the beneficiary has already paid for the services at issue.

Send the written request and above items to:

CGS Administrators, LLC - J15
P.O. Box 20006
Nashville, TN 37202

What to Include in Your Request for a Reconsideration of this Appeal

If you do not agree with this decision, you may file an appeal. When submitting your appeal, you will need to provide relevant laboratory test results such as vitamin B-12 and thyroid hormone obtained before the services were rendered, the results of mental status exams and cognitive tests to support a recent diagnosis of dementia and other diagnostic tests were inconclusive, an adjusted UB-04 of 137 bill type with the correct HCPCS code for the radioactive tracer rendered, and any other supporting documentation. When preparing your documentation, consider the appropriateness of the services being billed and verify the units of each service rendered are reported correctly.

Special note to Medicare physicians, providers, and suppliers only: Any additional evidence as indicated in this section should be submitted with the request for reconsideration. All evidence must be presented before the reconsideration decision is issued. If all additional evidence as indicated above is not submitted prior to issuance of the reconsideration decision, you will not be able to submit any new evidence to the Administrative Law Judge or the Medicare Appeals Council unless you can demonstrate good cause for withholding the evidence from the Qualified Independent Contractor.

You do not need to resubmit documentation that was submitted as part of the redetermination. This information will be forwarded to the QIC as part of the case file utilized in the reconsideration process.

Sincerely,

CGS Administrators, LLC - Jurisdiction 15
A Medicare Contractor

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

Your Right to Appeal this Decision: If you do not agree with this decision, you may file an appeal. An appeal is a review performed by people independent of those who have reviewed your claim so far. The next level of appeal is called reconsideration. A reconsideration is a new and impartial review performed by a Qualified Independent Contractor (QIC), separate and independent of CGS Administrators, LLC - J15.

How to Appeal: To exercise your right to an appeal, you must file a request in writing. Your request must be received by the QIC at the address below within 180 days of receiving this decision. You are presumed to have received this decision five days after the date of the letter unless there is evidence to show otherwise. If you are unable to file your appeal request timely, please explain why you could not meet the filing deadline. You may request an appeal by using the form enclosed with this letter.

If you do not use this form, you can write a letter. You must include: your name, the name of the beneficiary, the Medicare number, a list of the services or items that you are appealing and the dates of service, and any evidence you wish to attach. You must also indicate that CGS Administrators, LLC - J15 made the redetermination. You may also attach supporting materials, such as those listed in item 10 of the enclosed Reconsideration Request Form, or other information that explains why this service should be paid. Your doctor may be able to provide supporting materials.

If you want to file an appeal, send your request to:

MAXIMUS Federal Services Inc.
Medicare Part A West
3750 Monroe Avenue Suite 706
Pittsford, NY 14534-1302

Who May File an Appeal: You or someone you name to act for you "your appointed representative" may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you.

If you want someone to act for you, you may visit <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf> to download the "Appointment of Representative" form, which may be used to appoint a representative. Medicare does not require that you use this form to appoint a representative. Alternately, you may submit a written statement containing the same information indicated on the form. If you are a Medicare beneficiary, you may also call 1-800-MEDICARE (1-800-633-4227) to learn more about how to name a representative.

Other Important Information: If you want copies of statutes, regulations, policies, or manual instructions CMS used to arrive at this decision, or if you have any questions specifically related to your appeal, please write to us at the following address and attach a copy of this letter:

CGS Administrators, LLC - J15
A Medicare Contractor
P.O. Box 20006
Nashville, TN 37202

Resources for Medicare Beneficiaries: If you want help with an appeal, or if you have questions about Medicare, you can have a friend or someone else help you with your appeal. You can also contact your State Health Insurance Assistance Program (SHIP). You can find the phone number for your SHIP in your "Medicare & You" handbook, under the "Helpful Contacts" section of www.medicare.gov website, or by calling 1-800-MEDICARE (1-800-633-4227). Your SHIP can answer questions about payment denials and appeals.

For general questions about Medicare, you can call 1-800-MEDICARE (1-800-633-4227), TTY/TDD: 1-877-486-2048.

Remember that specific questions about your appeal should be directed to the contractor that is processing your appeal.

Reconsideration Request Form

Directions: If you wish to appeal this decision, please fill out the required information below and mail this form to the address shown below. At a minimum, you must complete/include information for items 1, 2a, 6, 7, & 11, but to help us serve you better, please include a copy of the redetermination notice with your request.

MAXIMUS Federal Services Inc.
Medicare Part A West
3750 Monroe Avenue Suite 706
Pittsford, NY 14534-1302

1. Name of Beneficiary: _____
- 2a. Medicare Number: _____
- 2b. Claim Number (ICN / DCN, if available): _____
3. Provider Name: _____
4. Person Appealing: ☐Beneficiary ☐Provider of Service ☐Representative
5. Address of the Person Appealing: _____

- 5a. Telephone Number of the Person Appealing: _____
- 5b. Email Address of the Person Appealing: _____
6. Item or service you wish to appeal: _____
7. Date of the service: From _____ To _____
8. Does this appeal involve an overpayment? ☐Yes ☐No
****Please include a copy of the demand letter with your request.***
9. Why do you disagree? Or what are your reasons for your appeal? (Attach additional pages, if necessary.)

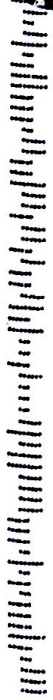
10. You may also include any supporting material to assist your appeal. Examples of supporting materials include:
☐ Medical Records ☐ Office Records/Progress Notes
☐ Copy of the Claim ☐ Treatment Plan ☐ Certificate of Medical Necessity
11. Name of Person Appealing: _____
12. Date: _____
Contractor Number: 15101



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